

SOME OBSERVATIONS ON GONORRHOEA AMONG WEST AFRICAN NEGROES*

BY

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In recent years a few studies have appeared of gonorrhoea in Africans, e.g., Blacklock (1931) and Willcox (1946a,b). West Africa is peculiarly suited to the study of this disease, as gonorrhoea is extremely common among the Negro population. It is often inadequately treated or even untreated, so that complications, rare in West Europe or the U.S.A., are commonplace. In short, the material is ideal, but accurate study is difficult owing to the shortage of trained staff and the casual attitude of the patient.

Incidence

Accurate figures are lacking. In general, women do not attend for treatment, either because the disease is less severe in women or because of their unemancipated position. They can only be persuaded to attend for complications, of which from their point of view sterility is the most important. The ratio of females : males attending the Lagos clinic was 1 : 7. In all countries the position is similar if not so extreme, the ratio being 1 : 4 in the United Kingdom (Ministry of Health Report, 1948). For this reason, the following observations are restricted to male patients.

In a large series of males between 20 and 45 years of age, who attended for other diseases, 42 per cent. admitted to having had gonorrhoea. This is much more accurate than the result of a similar enquiry would be among Europeans, for the African in general, does not consider gonorrhoea shameful. Europeans would as readily admit to having had the 'flu at one time or another. This figure agrees well with Blacklock's estimate of 50 per cent. for Sierra Leone.

The number of recent infections with gonorrhoea per thousand per annum is more difficult to compute. In the Lagos clinic, which serves a population of 230,000, we saw 2,500 new patients in one year. In addition, many patients remain untreated or

attend private practitioners. From these figures we estimate the incidence of gonorrhoea in males to be about 110 per thousand per annum.

A random series of male patients attending hospital for other diseases was questioned regarding gonorrhoea in the previous year, and the replies indicated an incidence of the order of 200 to 250 per thousand per annum; in this series we found 8 per thousand to be suffering from active gonorrhoea at the time of questioning and examination.

This figure is to be compared with 7 to 10 per thousand per annum in European and American civilians, and 11 to 50 in soldiers (Lees, 1946; Turner, 1943; Ministry of Health Report, 1948; Pelouze, 1941), whereas the rate for West African Negro soldiers approximated to 600 per thousand (Willcox, 1946a,b).

Field survey reports for 1947 to the Nigerian Medical Department (1949) showed 25, 125, and 800 per 1000 as being infected in Benue, the Cameroons, and the Eastern Provinces respectively.

Reasons for the High Incidence.—These can be summarized as promiscuity and inadequate treatment, along with great delay in seeking treatment, which aggravates the disease and also makes transmission to others more probable.

In a series of 100 patients attending the clinic with first attacks of gonorrhoea, the average delay before seeking treatment was 16 days. Those who had tried "native medicine" before coming to the clinic had delayed, on an average, for 31 days, the longest period of trial of native remedies we have encountered being 5 years. Analysis of a series of cases with second or subsequent attacks of gonorrhoea gave substantially the same figures regarding delay, especially when native remedies had been tried first.

We inquired into the reasons for this delay. Native medicines are quite ineffective; we tried these remedies on two volunteers and found them quite inactive. There is seldom much difficulty in

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reaching a treatment centre, but since the patient prefers to keep his disease secret from his family, friends, and neighbours, he often chooses to buy a few tablets of a sulphonamide or some other "white man's medicine" in the black market.

It is not that the African is stupid and ignorant; in most respects he is intelligent. It is not that free treatment is suspect; he is usually a thrifty person.

The major factor causing delay is that he is quite indifferent to the disease and regards a "cold in the pipe" with less concern than a European does a "cold in the nose". He seeks medical aid when, in his graphic Doric, "it bites him too much", and he defaults as soon as his major symptoms have abated. There is much truth in the local dictum that "Nature treats the gonorrhoea, while the doctor treats the complications".

Native Remedies.—These are usually family secrets handed down from generation to generation. A grateful native "doctor" (who could not, however, cure his own discharge) provided me with some samples of his concoctions. He used mainly vegetable ingredients, which were macerated in plain water; on trial they were no improvement on potassium citrate.

Complications of Gonorrhoea

In 200 consecutive cases the presenting symptoms were:—

	%		%
Urethritis { acute	51	Haematuria	1
chronic	16	Feelings of weakness	
Epididymo-orchitis	11	and rheumatic pains	1
Arthritis	7	Stricture	1
"Waist pain" . . .	6	Gonococcal bubo	} less than 1
Urethral irritation .	3	Sterility	
(no gross discharge)		Follicular abscess	
Eye symptoms . .	2	Prostatic abscess	1

Practically every African with gonorrhoea complains of "waist pain", a symptom seldom experienced by Europeans. In the cases so listed this was the only complaint, but they proved to be harbouring gonococci. I believe it results from excessive sexual stimulation. No cases of rectal gonorrhoea have been seen; its rarity was also noted by Willcox (1946a, b).

One woman had most of the mucous membranes affected, morphological gonococci being isolated from eyes, lips, and vagina, but the rectum was free. She also had keratoderma blennorrhagica and later developed arthritis.

Arthritis.—Arthritis did not respond to anti-histamine drugs. In Nigeria we have found cases

of arthritis arising several years after the original infection, the longest being 25 years, though this case was not confirmed bacteriologically.

All cases that had proved resistant to treatment improved (at least temporarily) when admitted to hospital and treated with fever and chemotherapy. Cases that are apparently sulphonamide-resistant may be simply due to the fact that patient has sold his tablets instead of swallowing them. Penicillin must be administered by a reliable member of the staff, otherwise the patient may be given short measure or an ineffective substitute, and the penicillin sold to another sufferer "under the counter".

Continued sexual excitement and intercourse during the course of the disease is not uncommon, and leads to aggravation and continuation of the infection. Patients often attend not on account of urethral discharge, but because of pain on erection or diminution of potency.

Non-Specific Urethritis.—This was found to account for 33 per cent. of our cases. Streptomycin was of considerable value in treatment.

Comment

Gonorrhoea is very prevalent in West Africa, and is a social and educational problem as well as a medical one. The incidence is not likely to be reduced until moral and educational standards improve. Even mass treatment of the population by penicillin is not likely to prove effective, though the results of experiments in Haiti will be interesting, as the problem in West Africa is similar. The disease is serious in West Africa on account of the loss of economic efficiency it entails.

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